

**Nebraska's
Comprehensive Health
Insurance Pool
CHIP**

**Health Care
Coverage**

administered by
**Blue Cross and Blue Shield
of Nebraska**

An independent licensee of the Blue Cross and
Blue Shield Association.

Note: Treatment of a pre-existing condition is a noncovered service until the policy has been in force for at least six months (unless a waiver is in effect). Please see the "Pre-existing Conditions" section of this brochure for further details.

WHAT IS CHIP?

CHIP was created by the Nebraska legislature in 1985 to provide health care coverage to people who can't otherwise obtain it at an affordable price or without health restrictions. If you've had trouble getting health insurance for medical reasons, this state program may help you obtain the coverage you need.

All insurers authorized to issue or provide health care coverage in Nebraska are members of CHIP. Blue Cross and Blue Shield of Nebraska is the administrator of the program, responsible for determining applicant eligibility, collecting premiums and paying claims.

WHO IS ELIGIBLE FOR CHIP?

To be eligible to purchase CHIP coverage, you must qualify under one of the following:

1. Be a legal Nebraska resident at least six months prior to application*; and
 - a. Have been rejected for health insurance coverage for medical reasons within the last six months from a Nebraska insurer; or
 - b. Have been offered health insurance coverage within the last six months which includes a restrictive rider limiting coverage for a pre-existing medical condition; or
 - c. Have been refused health insurance coverage comparable to that available through CHIP or have been offered a comparable coverage at a higher premium within the last six months;

2. Be a legal Nebraska resident,* and
 - a. Have an aggregate of at least 18 months prior creditable coverage, most recently under a group health plan, governmental plan or church plan; and
 - b. Not be eligible for another group health plan, Medicare or Medicaid, or have other health insurance coverage; and
 - c. Continuation coverage under COBRA or a similar program, if offered, has been exhausted, or COBRA or similar insurance is at a higher rate than CHIP; or
3. You have one of the specified conditions listed on pages 17 and 18 of this brochure. If so, you are automatically eligible for CHIP enrollment, provided that you have been a Nebraska resident at least six months prior to application.*
4. Be a legal Nebraska resident*, and potentially eligible for the Health Coverage Tax Credit under the Trade Adjustment Assistance Reform Act of 2002.

If you're eligible for Medicare (by reason of age), Medicaid or other medical assistance, you cannot purchase CHIP coverage. If you have CHIP coverage, it will terminate when you become eligible for Medicaid or Medicare by reason of age. A person who becomes eligible for Medicare for reasons other than age (i.e. disability, kidney transplant, dialysis) will continue to be eligible for CHIP coverage.

** To be eligible for continued CHIP coverage, you must maintain residency in the state of Nebraska.*

REDUCTION IN BENEFITS

If you are covered by other insurance, a major medical plan, or a local, state or federal program, CHIP benefits will be reduced by all amounts payable under your other plans.

NON-TOBACCO USER PREMIUM DISCOUNT

If you do not use tobacco products (i.e. cigarettes, cigars, pipes, chewing tobacco), you are eligible to receive a discount on your monthly CHIP premium.

PRE-EXISTING CONDITIONS

Treatment of a pre-existing condition is a noncovered service until the CHIP policy has been in effect for at least six months. However, this exclusion may be waived if one of the following events occurs:

1. Health coverage was involuntarily terminated because:
 - ❖ the insurer withdrew from the state;
 - ❖ the employer or employer trust fund declared bankruptcy or insolvency;
 - ❖ the employer ceased to provide any group health plan for its employees.

The person must be eligible for CHIP coverage and must apply for the pre-existing condition waiver within 60 days after termination of prior coverage. The CHIP board may assess additional premiums for this waiver. The person cannot be eligible for a conversion policy or a continuation of coverage policy under federal or state law.

2. The applicant received medical assistance through the Medically Handicapped Children's Program within six months of the effective date of CHIP coverage.
3. The applicant was an organ transplant recipient terminated from Medicare within six months of the effective date of CHIP coverage.
4. Medicaid coverage ended within six months of the effective date of CHIP coverage.

5. Coverage under a continuation of coverage policy under federal or state law terminated for reasons other than non-payment. Application for CHIP coverage must be made within 90 days of the end of prior coverage.
6. The applicant has 18 months of prior creditable coverage which has terminated within 63 days of the application date, and meets the eligibility requirements described in #2 on pp. 1-2 of this brochure

In all cases, the applicant must provide documentation to verify eligibility for the waiver.

PREADMISSION CERTIFICATION & CONCURRENT REVIEW

The Preadmission Certification and Concurrent Review Programs work to ensure that needed medical care is received in the most appropriate and cost-effective setting. Many times care can be provided more conveniently and comfortably without having to be admitted into the hospital, such as in an outpatient facility, a doctor's office -- or even in your own home.

HOW THE PROGRAM WORKS

When you are hospitalized in a PPO hospital, there is no need for CHIP benefit precertification, except when the admission is for treatment of mental illness, drug abuse or alcoholism.

If you are hospitalized in a non-PPO hospital, you must certify benefits as described below. You must also certify benefits whenever the admission is for the treatment of mental illness, drug abuse or alcoholism, whether or not your hospital and doctor are in the PPO network.

❖ Non-emergency hospitalizations

All non-emergency hospital stays must be approved for benefit payment prior to admission.

You or your physician must call Blue Cross and Blue Shield of Nebraska prior to any non-emergency hospital admission. You will receive written notification of whether or not benefits for the hospitalization are available. If the proposed inpatient care is determined to be the most medically appropriate setting for your health care according to established criteria, benefit payment will be authorized according to the terms of the CHIP policy.

❖ **Emergency admissions**

If the hospitalization is the result of an accident or medical emergency, you or your physician must call Blue Cross and Blue Shield of Nebraska within 24 hours of your admission or during the next business day. Blue Cross and Blue Shield of Nebraska will contact you and your physician to confirm that benefits are available for the hospitalization, and the number of days that have been approved.

❖ **Extending a hospital stay**

If you are hospitalized longer than was originally approved, those additional days must be certified for benefit payment. If additional days are determined to be medically necessary, benefits for covered services will be paid according to the terms of your CHIP policy. If additional days are determined to be not medically necessary, all benefits for those days will be denied.

To certify CHIP benefits for an inpatient hospitalization, call 390-1870 (Omaha) or 1-800-247-1103 (toll free).

If you do not follow these procedures, all benefits for covered medically necessary services will be reduced by 25%. Benefits for all charges CHIP considers not medically necessary will be denied.

IMPORTANT: Certification is not a guarantee of benefit payment. If certified, available benefits for your hospital stay will be determined according to

the terms of your policy. This means benefits will be subject to membership eligibility, waiting periods, any deductible and coinsurance requirements, limitations and exclusions.

CHIP PPO COVERAGE

PPO stands for “preferred provider organization.” PPOs are special arrangements between an insurer and a network of hospitals, doctors and other health care providers to pay for customers’ medical care.

Blue Cross and Blue Shield of Nebraska has contracted with a network of hospitals and doctors to provide CHIP customers with medical care. As a result, you pay less out of pocket when you use these PPO providers. If you use a doctor or hospital which is not in the PPO network, benefits for covered services are still available, but are subject to the non-PPO deductible and coinsurance.

Be sure to ask your doctor prior to receiving treatment if he or she is a PPO provider. If your PPO doctor refers you to a specialist, ask if that specialist is also in the PPO network.

To obtain an updated listing of PPO hospitals and doctors, contact CHIP Customer Service.

IN-NETWORK BENEFITS AWAY FROM HOME

As the administrator of the CHIP program, Blue Cross and Blue Shield of Nebraska offers you access to a national PPO network called the BlueCard Program.

To access your benefits wherever you are, all you have to do is use hospitals and doctors in the local Blue Cross and Blue Shield Plan’s **BlueCard** PPO provider network. When you do, you also enjoy the discount and claim filing agreements Blue Cross and

Blue Shield Plans across the country have negotiated with the BlueCard doctors and hospitals in their area.

How to Locate BlueCard PPO Providers Nationwide

By phone: 1-800-810-BLUE (2583)
On the Web: www.bcbs.com

ALLOWABLE CHARGE

Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by PPO and Participating providers will be the contracted amount. The allowable charge for services by noncontracting providers will generally be the lesser of the billed charge or the Reasonable Allowance for the service.

CHOICE OF TEN CALENDAR YEAR DEDUCTIBLES

- Option 1: \$500 PPO/\$1,000 non-PPO
- Option 2: \$1,000 PPO/\$2,000 non-PPO
- Option 3: \$1,500 PPO/\$3,000 non-PPO
- Option 4: \$2,000 PPO/\$4,000 non-PPO
- Option 5: \$3,000 PPO/\$6,000 non-PPO
- Option 6: \$4,000 PPO/\$8,000 non-PPO
- Option 7: \$5,000 PPO/\$10,000 non-PPO
- Option 8: \$7,500 PPO/\$15,000 non-PPO
- Option 9: \$10,000 PPO/\$20,000 non-PPO
- Option 10: **NEW!** HSA-Eligible Plan
\$2,000 PPO/\$4,000 non-PPO

YOUR COINSURANCE AND MAXI- MUM COINSURANCE EXPENSE

After you have met your calendar year deductible, you pay a certain percentage of allowable charges (called "coinsurance") until you reach the maximum coinsurance expense. The maximum coinsurance expense is the most you pay out of your own pocket in coinsurance in a calendar year. Once you reach this maximum, you pay nothing for most covered services for the rest of the calendar year.

Note: Under Options 1 through 9, the coinsurance you pay for mental illness, drug abuse and alcoholism treatment does not apply toward the maximum coinsurance expense. Coinsurance for mental illness, drug abuse and alcoholism treatment does apply toward the maximum coinsurance expense under Option 10.

A BRIEF SUMMARY OF OPTIONS 1 THROUGH 9

	In-Network	Out-of-Network
Calendar year deductible	See listing of deductible options on page 6	
Maximum coinsurance expense per calendar year	\$1,500	\$3,000
Coinsurance you pay for most hospital/medical/surgical covered services	20% of allowable charges	30% of allowable charges
Mental illness, drug abuse & alcoholism treatment	50% of allowable charges	60% of allowable charges
Office visits	\$10 copay	Benefits subject to deductible & coinsurance
Prescription drug copays, per 30-day supply		
Generic drugs		\$10
Formulary brand name drugs		\$25
Nonformulary drugs		\$40
CHIP policy maximum for mental illness, drug abuse and alcoholism benefits		\$25,000
Overall CHIP policy maximum		\$1 million

A BRIEF SUMMARY OF HSA-ELIGIBLE OPTION 10

	In-Network	Out-of-Network
Calendar year deductible	\$2,000	\$4,000
Calendar year out-of-pocket maximum (includes deductible)	\$5,000	\$10,000
Coinsurance you pay for most hospital/medical/surgical covered services	20% of allowable charges	40% of allowable charges
Mental illness, drug abuse & alcoholism treatment	50% of allowable charges	60% of allowable charges
Office visits	Benefits subject to deductible & coinsurance	Benefits subject to deductible & coinsurance
Prescription drug benefits	Benefits for covered prescription drugs are subject to the in-network deductible and coinsurance.	
CHIP policy maximum for mental illness, drug abuse and alcoholism benefits		\$25,000
Overall CHIP policy maximum		\$1 million

WHAT IS AN HSA-ELIGIBLE PLAN?

CHIP Option 10 is an HSA-eligible health plan. HSA stands for "Health Savings Account." An HSA is a special tax-exempt account established through a qualified financial institution to pay for medical expenses.

In general, any individual who is covered under a "high deductible health plan" is eligible to establish an HSA. To qualify as a high deductible health plan, the plan must satisfy certain requirements with respect to deductibles and out-of-pocket expenses.

Funds in an HSA may be used to pay qualified medical expenses not reimbursed by insurance. Examples include deductibles and coinsurance, charges for noncovered services, and health and long term care insurance premiums. Withdrawals for other purposes are taxable (and before age 65, subject to a 10% penalty).

Individuals may contribute up to 100% of the calendar year deductible amount into an HSA, not to exceed the maximum individual contribution amount established by the Internal Revenue Service.

COVERED SERVICES

If you qualify to purchase CHIP coverage, you are eligible to receive the benefits briefly described in this brochure. Please refer to the CHIP PPO policy for a complete description of covered and noncovered services and supplies.

❖ Hospital room and board

Pays for the cost of a semi-private room. If the hospital has all private (one-bed) rooms, the average cost of a semiprivate room will be applied toward the charge for the private room. Benefits are also available for cardiac and intensive care units.

❖ **Physician charges**

We pay CHIP benefits for medically necessary covered services up to the allowable charge.

❖ **Physical therapy**

Pays benefits for services of a licensed physical therapist or licensed physical therapist assistant supervised by the licensed physical therapist.

❖ **Speech therapy**

Speech therapy is payable when covered services are received from a licensed speech-language pathologist or registered communications assistant practicing under the direct supervision of a licensed speech-language pathologist.

❖ **Occupational therapy**

Services must be provided by a licensed occupational therapist or licensed occupational therapist assistant under the supervision of the licensed occupational therapist. Outpatient sessions are limited to no more than 60 four-hour sessions per calendar year.

❖ **Anesthetics and their administration**

Services must be performed by a physician or a certified registered nurse anesthetist.

❖ **X-ray and lab**

❖ **Routine screening mammograms**

❖ **Ambulance service in an emergency**

Benefits are available for ambulance service to the nearest facility for appropriate care in a medical emergency. Benefits are also available for transportation within the U.S. by a professional non-air ambulance or on a regularly scheduled flight on a commercial airline when: (1) special and unique covered hospital expenses are required which are not provided by a local hospital; (2) transportation is medically necessary; and (3) transportation is to the nearest hospital equipped to furnish the services.

❖ **Skilled nursing facility care**

Benefits are available for a maximum of 30 days each calendar year, subject to the conditions stated in the CHIP PPO policy. The skilled nursing facility stay must occur within 14 days of a hospitalization lasting a minimum of three consecutive days.

❖ **Cardiac and pulmonary rehabilitation**

A maximum of six consecutive weeks of outpatient cardiac or pulmonary rehabilitation is available, subject to the conditions stated in the policy.

❖ **Medical supplies & equipment**

Benefits are available for rental or initial purchase of certain items of medically necessary home medical equipment when prescribed by a physician. Please refer to the CHIP PPO policy for further details.

❖ **Renal dialysis**

❖ **Home infusion therapy**

❖ **Oxygen and equipment for its administration**

❖ **Inhalation therapy**

❖ **Hospice care**

Covered services include inpatient hospice care, physician's services and home health aide services. Counseling (other than bereavement counseling) for the covered person's immediate family (spouse, children, parents) is payable up to a total policy maximum benefit of \$500. Bereavement counseling for the covered person's immediate family will be payable up to a total policy maximum benefit of \$100. **Please note:** limitations apply to these benefits, so please refer to the CHIP PPO policy for further information.

❖ **Home health care**

Benefits are available for 40 days of home health care each calendar year, paid as follows:

- ❖ For the first 10 days of home health care

in a calendar year, you pay no coinsurance for eligible expenses, subject to the deductible.

- ❖ For the next 30 days of home health care in a calendar year, you pay 20% of eligible expenses.

❖ **Mental illness, drug abuse and alcoholism**

CHIP benefits are available for medically necessary covered inpatient and outpatient services, up to a total policy maximum of \$25,000. When PPO providers are used, you pay 50% of allowable charges for covered inpatient and outpatient services. When non-PPO providers are used, you pay 60% of allowable charges for covered inpatient and outpatient services.

Inpatient benefits are available for 30 days per calendar year. Benefits for outpatient services are available for up to 60 units per calendar year. One unit of outpatient treatment is defined as: (1) one individual or group therapy session; (2) one day in a licensed day or partial hospitalization program; (3) one day in a certified alcoholism and drug abuse partial care program; (4) one biofeedback procedure.

Services may be received from a qualified physician, licensed clinical psychologist, licensed special psychologist or licensed mental health practitioner. The licensed mental health practitioner may also be a licensed professional counselor or a licensed clinical social worker. When under the supervision of and billed by one of the above types of professional, services may also be received from a psychiatric nurse, certified social worker, certified alcoholism and drug abuse counselor or other provider approved by state law.

Please note: Coinsurance for mental illness, drug abuse and alcoholism treatment is not applied toward the maximum out-of-pocket expense. Inpatient admissions must be precertified for benefit payment. Please see your CHIP

PPO policy or the "Preadmission Certification and Concurrent Review" section of this brochure.

❖ **Diabetes education**

You are responsible for 10% of allowable charges for the cost of completing a diabetes education program. The calendar year deductible does not apply.

Educational benefits are available up to a maximum of \$500 in a two-year period. Services must be prescribed by a physician and provided by an American Diabetes Association-recognized diabetes self-management education program or health care professional certified by the National Certification Board for Diabetes Educators.

❖ **Prescription drugs**
Options 1 through 9

Your benefits are based on the Blue Cross and Blue Shield of Nebraska Drug Formulary, a listing of medications divided into three tiers. The copay you pay for each 30-day supply of your covered prescription drug depends on what tier your medication is in. Please refer to the chart on page 7 for your prescription drug copay amounts.

The drug formulary is revised on a regular basis. The website provides you with the most up-to-date version of the drug formulary: www.bcbsne.com/members/drugformularies.asp.

To access your CHIP prescription drug benefits, you must present your CHIP I.D. card, along with your doctor's prescription, at a participating pharmacy. At the time of purchase, you will be required to pay your plan's applicable copay amount, as shown on the chart, for a 30-day supply of a covered medication.

Please note: Whenever appropriate, generic drugs will be used to fill your prescriptions. If you prefer a brand name drug, you will be responsible for the difference in cost, plus the applicable copay amount.

Option 10

Your prescription drug benefits are subject to your plan's in-network deductible and coinsurance amounts. Once the deductible has been satisfied, we will reimburse you for the cost of the covered prescription drug, minus your coinsurance.

When you use a participating Rx Nebraska pharmacy, you'll automatically receive a special pre-negotiated discount on most of your prescription drugs. (The actual discount you receive depends on the pharmacy and the type of drug you purchase.)

❖ Women's Health and Cancer Rights Act

Services are covered in accordance with the Women's Health and Cancer Rights Act, which requires that a group health plan providing medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment of physical complications.

❖ Oral surgery

CHIP benefits are available for the following types of oral surgery and dentistry: removal of bony growths, tumors and cysts; cutting and draining of cellulitis; surgery involving the TMJ (temporomandibular jaw joint); the reduction of a complete dislocation or fracture of the TMJ required as a direct result of an accident or injury. Services must be received within 12 months of the date of the injury. Benefits are not available when the TMJ dislocation or fracture occurs as a result of eating, biting or chewing.

Benefits are also available for the removal of impacted teeth on an outpatient basis and bone grafts to the jaw (except those done to prepare the mouth for dentures or for periodontal purposes).

Also covered are services, supplies and appliances for dental treatment of natural teeth required as the direct result of an accidental injury. Benefits are limited to treatment provided within 12 months of the date of injury. Injuries resulting from eating, chewing or biting are not covered.

Osteotomies performed for gross abnormalities of the jaw are payable when orthodontic treatment or appliances cannot correct the condition.

Please note: CHIP will cover inpatient hospital admissions related to oral surgery and dentistry, but only if you have a nondental physical condition which makes hospitalization essential to safeguard your life and health or if it is medically necessary as determined by CHIP.

❖ **Organ and tissue transplants**

The Comprehensive Health Insurance Pool, in conjunction with Blue Cross and Blue Shield of Nebraska, has developed a listing of Preferred Transplant Centers in cities across the country. When you use one of these facilities for a covered organ and/or tissue transplant, benefits are not subject to the \$100,000 transplant maximum. Instead, benefits for covered services are only subject to the policy's overall \$1 million maximum. If, however, you choose not to use a Preferred Transplant Center, benefits for covered services will be subject to a \$100,000 transplant maximum.

❖ **Hospital preadmission testing**

When you receive covered services for hospital preadmission testing, you pay no coinsurance for covered services, subject to the limitations in the CHIP policy. The calendar year deductible is not applied.

❖ **Routine care benefits**

Under all plans, up to \$150 in benefits is available each calendar year for routine care. Covered services include office visits, cardiac stress tests, lab and radiology, Pap smears and immunizations. If a PPO provider is used, no deductible or coinsurance is applied. If a non-PPO provider is used, benefits are subject to the non-PPO deductible and coinsurance.

Pediatric immunizations are payable without application of the deductible, subject to applica-

ble coinsurance. Pediatric immunizations include a complete set of vaccinations for children from birth to six years of age for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, chicken pox and haemophilus influenza type B. These immunizations do not count toward the \$150 routine care benefit.

❖ **\$10 office visit copay**

Under Options 1 through 9, when a PPO physician is used, you pay only a \$10 copay for a diagnostic office visit exam. Copay amounts do not apply toward the maximum out-of-pocket expense.

❖ **Maternity care (Optional)**

If you have been covered by the optional Maternity Benefit Rider for at least nine months prior to the birth of your child and have been continuously covered throughout the pregnancy, benefits are available for covered services for normal pregnancy and childbirth. Benefits are subject to a \$3,000 policy maximum. Please note: If you are eligible for a waiver of the pre-existing condition exclusion and purchase the maternity rider at initial application, this nine-month coverage requirement may be waived or reduced.

❖ **Newborn coverage**

Unless you are covered under the Optional Maternity Benefit Rider, benefits for normal pregnancy and childbirth are not available. However, whether or not you have optional CHIP maternity coverage, benefits for covered services are available for your newborn for 31 days from the date of birth. CHIP coverage for the newborn shall terminate at the end of this 31 day period.

NONCOVERED SERVICES

The following is a partial listing of the exclusions and limitations that apply to CHIP PPO coverage. For a complete list, please refer to the policy.

No benefits are available for the following:

- ❖ Services not specifically covered by this policy, or amounts in excess of charges for covered services.
- ❖ Charges in excess of the Reimbursement Schedule Amount.
- ❖ Services or supplies which are not actually provided while the policy is in force.
- ❖ Any service or supply which would be provided without cost to you in the absence of insurance.
- ❖ Services performed by a member of your family.
- ❖ Orthodontics, dental splints or appliances; treatment, filling, removal, repositioning, replacement or movement of teeth or tissues next to the teeth (except due to injury).
- ❖ Injuries or sickness covered by Workers' Compensation or employers' liability laws.
- ❖ Care or treatment in a hospital owned or operated by the government or any of its agencies.
- ❖ Eye refractions, glasses, contacts, eye exercises or visual training (orthoptics).
- ❖ Routine audiological exams, audiant bone conductors or hearing aids and their fitting.
- ❖ Refractive corneal surgery (except grafts).
- ❖ Private duty nursing.
- ❖ Loss resulting from duty in the armed services.
- ❖ Loss resulting from an act of declared or undeclared war.
- ❖ Normal pregnancy/childbirth without optional Maternity Benefit Rider coverage.
- ❖ Voluntary abortion.
- ❖ Care of a newborn infant.
- ❖ Complications of pregnancy when the pregnancy had its inception before the effective date of coverage.
- ❖ Gender transformations/changes.
- ❖ Fertility tests and related services.
- ❖ Reversal of surgical sterilization.

- ❖ Direct attempts to cause pregnancy by hormone therapy, artificial insemination, invitro fertilization or embryo transfer.
- ❖ Routine physical exams or tests in excess of the benefits allowed under this policy.
- ❖ Self-inflicted injuries.
- ❖ Transplant expenses when you are the donor.
- ❖ Treatment of a pre-existing condition until the policy has been in force at least six months (unless pre-existing condition waiver is in force).
- ❖ Investigative/experimental treatment.
- ❖ Expenses covered by local, state or federal programs.
- ❖ Services covered by another insurance plan.
- ❖ Custodial care.
- ❖ Therapy which is primarily recreational or educational; music therapy, work-hardening therapy, pre-vocational therapy, or any forms of nonmedical self-care.
- ❖ Genetic treatment or engineering.
- ❖ Cognitive training.
- ❖ Weight modification or treatment of obesity, including surgery.
- ❖ Transplant surgery which has not been preauthorized.
- ❖ Services by or for blood donors.
- ❖ Breast reduction/augmentation.
- ❖ Charges made separately for services, supplies or other materials considered by the CHIP administrator to be included within the total charge payable.
- ❖ Services not determined payable after consideration by the Utilization Review program.

This program evaluates use of a medical/surgical procedure or service or the utilization of medical supplies, drugs or durable medical equipment compared to established criteria, to determine whether benefits are payable. Benefits for services, procedures, drugs, sup-

plies or durable medical equipment determined not medically necessary are not payable.

- ❖ Orthopedic shoes or foot supports except as prescribed for complications of diabetes.
- ❖ Convenience or personal items.
- ❖ Nutrition care supplements.

CHIP SPECIFIED CONDITIONS

If you have one of the following conditions, and have been a legal Nebraska resident for at least six months prior to application, you are automatically eligible for CHIP coverage.

- ❖ AIDS
- ❖ Angina Pectoris
- ❖ Arteriosclerosis Obliterans
- ❖ Artificial heart valve
- ❖ Ascite
- ❖ Cardimyopathy
- ❖ Chemical dependency
- ❖ Cirrhosis of the liver
- ❖ Coronary insufficiency
- ❖ Coronary occlusion
- ❖ Cystic Fibrosis
- ❖ Dermatomyositis
- ❖ Friedreich's Disease
- ❖ Huntington's Chorea
- ❖ Hydrocephalus
- ❖ Intermittent claudication
- ❖ Juvenile diabetes
- ❖ Kidney failure requiring dialysis
- ❖ Lead poisoning with cerebral involvement
- ❖ Leukemia
- ❖ Lupus Erythematosus Disseminate

plies or durable medical equipment determined not medically necessary are not payable.

- ❖ Orthopedic shoes or foot supports except as prescribed for complications of diabetes.
- ❖ Convenience or personal items.
- ❖ Nutrition care supplements.

CHIP SPECIFIED CONDITIONS

If you have one of the following conditions, and have been a legal Nebraska resident for at least six months prior to application, you are automatically eligible for CHIP coverage.

- ❖ AIDS
- ❖ Angina Pectoris
- ❖ Arteriosclerosis Obliterans
- ❖ Artificial heart valve
- ❖ Ascite
- ❖ Cardimyopathy
- ❖ Chemical dependency
- ❖ Cirrhosis of the liver
- ❖ Coronary insufficiency
- ❖ Coronary occlusion
- ❖ Cystic Fibrosis
- ❖ Dermatomyositis
- ❖ Friedreich's Disease
- ❖ Huntington's Chorea
- ❖ Hydrocephalus
- ❖ Intermittent claudication
- ❖ Juvenile diabetes
- ❖ Kidney failure requiring dialysis
- ❖ Lead poisoning with cerebral involvement
- ❖ Leukemia
- ❖ Lupus Erythematosus Disseminate

- ❖ Malignant tumor (if treated or has occurred within the last four years)
- ❖ Metastatic cancer
- ❖ Motor or sensory aphasia
- ❖ Multiple or Disseminated Sclerosis
- ❖ Muscular Atrophy or Dystrophy
- ❖ Myasthenia Gravis
- ❖ Myotonia
- ❖ Open heart surgery
- ❖ Paraplegia or quadriplegia
- ❖ Parkinson's Disease
- ❖ Peripheral arteriosclerosis (if treated within the last three years)
- ❖ Polyarteritis (periarteritis nodosa)
- ❖ Posterolateral Sclerosis
- ❖ Psychotic disorders
- ❖ Silicosis
- ❖ Splenic anemia (True Banti's Syndrome)
- ❖ Still's Disease
- ❖ Stroke
- ❖ Syringomyelia
- ❖ Tabes Dorsalis (locomotor ataxia)
- ❖ Thalassemia (Cooley's or Mediterranean anemia)
- ❖ Topectomy and lobotomy
- ❖ Wilson's Disease

CHIP CUSTOMER SERVICE

Omaha (402) 343-3574
Toll-free 1-877-348-4304

MAILING ADDRESS

Blue Cross and Blue Shield of Nebraska
CHIP Administrator
P.O. Box 3248
Omaha, NE 68180-0001

This brochure contains only a partial description of the benefits, limitations, exclusions and other provisions of CHIP coverage. It describes the more important parts of the contract in a general way, and should not be considered to be all or part of the contract. If you have questions regarding costs or further details of the coverage (including exclusions, reductions, limitations and terms under which the policy may be continued in force), or you need assistance, contact the CHIP Customer Service Center.

Notice Required By Federal Law

- ❖ Not a deposit.
- ❖ Not FDIC insured.
- ❖ Not insured by any federal government agency.
- ❖ Not guaranteed by any bank.

